

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155291		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/15/2013	
NAME OF PROVIDER OR SUPPLIER  EAGLE VALLEY MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214			
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00121231.</p> <p>Complaint IN00121231 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: January 7, 8, 9, 10, 11, 14, and 15, 2013.</p> <p>Facility number: 000188 Provider number: 155291 AIM number: 100266310</p> <p>Survey team: Heather Lay, RN - TC (January 7, 9, 10, 11, 14, and 15, 2013) Lori Brettnacher, RN (January 7, 8, 9, 10, 11, 14, and 15, 2013)</p> <p>Census bed type: SNF: 6 SNF/NF: 86 Total: 92</p> <p>Census payor type: Medicare: 11 Medicaid: 72 Other: 9</p>			F0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Review on or after 02/14/13.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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	<p>Total: 92</p> <p>Sample: 38</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed 01/23/2013 by Brenda Nunan, RN.</p>						

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F0156 SS=E	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>						

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on observation and interview, the facility failed to ensure information regarding Medicare, Medicaid, and how to contact advocacy agencies was readily accessible to residents who resided on a locked dementia unit. This deficient practice affected 20 of 20 residents who resided on the locked dementia unit.</p> <p>Findings include:</p> <p>On 1/14/13 at 2:30 P.M., an environmental tour of the locked dementia unit was initiated. At that time, information regarding Medicare, Medicaid, and how to contact advocacy agencies was not located.</p> <p>During an interview on 1/14/2013 at 2:30 P.M. the Memory Care Director indicated the appropriate contact</p>	F0156	<p>F 156 Notice of Rights, Rules, Services, Charges. It is the practice of this facility to ensure information regarding Medicare, Medicaid, and how to contact advocacy agencies is readily accessible to residents who reside on a locked dementia unit.</p> <p>1. There was no resident identifier for the alleged deficient practice.</p> <p>2. Residents who reside on the Dementia unit have the potential to be affected by the alleged deficient practice.</p> <p>3. This requirement was met immediately by posting the required information including, but not limited to information regarding Medicare, Medicaid and the contact information for the State Ombudsman and other Advocacy Agencies. MCF and Memory Care Staff have been educated that this information is required to be posted at all times</p>	02/14/2013			

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	<p>numbers were posted inside a closed cabinet door in the nurse's station. Residents did not have access to this cabinet. She indicated all her residents were cognitively impaired and she was not aware the information needed to be posted on the unit.</p> <p>3.1-3(b)(1)</p>			<p>by DNS by February 14, 2013 4.ED/designee will monitor postings monthly to ensure compliance.</p>			

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F0167 SS=E	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to ensure survey results were readily accessible to the residents of a locked dementia unit. This deficient practice affected 20 of 20 residents who resided in the locked dementia unit.</p> <p>Findings include:</p> <p>On 1/14/2013 at 2:30 P.M., an environmental tour of the locked dementia unit was initiated. At that time, the survey book or a sign [stating where to locate the survey book] was not observed on the unit.</p> <p>During an interview on 1/14/2013 at 3:00 P.M. the Executive Director indicated she was not aware the information needed to be available in the locked unit.</p> <p>3.1-3(b)(1)</p>		F0167	<p>F 167 Right to Survey Results-Readily Accessible It is the practice of this facility to ensure survey results are readily accessible to the residents of a locked dementia unit.</p> <p>1. There was no resident identifier for the alleged deficient practice.</p> <p>2. Residents who reside on the Dementia unit have the potential to be affected by the alleged deficient practice.</p> <p>3. This requirement was met immediately by posting a survey book with results on the unit for residents and visitors to review. MCF and Memory Care Staff have been educated that this information should be accessible at all times by DNS by February 14, 2013</p> <p>4. ED/designee will monitor postings monthly to ensure compliance.</p>		02/14/2013	

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F0247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to give notice to residents who had a room mate change for 2 of 5 residents interviewed regarding receiving notice prior to receiving a new room mate (Resident #7 and Resident #120).</p> <p>Findings:</p> <p>1) Resident #7's record was reviewed on 1/11/2013 at 12:22 P.M. Resident #7 was admitted to this facility on 10/5/2010 and readmitted on 10/29/2011. Resident #7 had current diagnoses which included: renal disease-end stage, diabetes mellitus, and blindness. A quarterly minimum data set assessment tool (MDS), dated 11/15/12, indicated Resident #7 was cognitively intact.</p> <p>During an interview on 1/10/2013 at 10:07 A.M., Resident #7 indicated he had received a room mate change with in the last 9 months. He denied receiving notice from facility staff prior to the room mate moving into his room. He stated, "They just bring them in."</p>		F0247	<p>F 247 Right To Notice Before Room/Roommate Change. It is the practice of this facility to ensure that resident receives notice before the resident's room or roommate in the facility is changed. 1.Resident #7 was visited by social services to ensure there were no psychosocial issues. Resident # 120 was visited by social services to ensure there were no psychosocial issues. 2.Residents who have room moves and new roommates have the potential to be affected by the alleged deficient practice. 3.Social Service was re-educated by Social Service Consultant by February 14, 2013 on proper documented notification and follow up from room moves and new roommates. 4.A Social Service Documentation Review CQI tool will be utilized weekly x 4 and monthly x 6 months. If threshold is not achieved, an action plan will be developed and reviewed by the CQI committee.</p>		02/14/2013	

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	<p>During an interview on 1/14/2013 at 2:11 P.M., The Memory Care Facilitator indicated the facility was currently without a Social Service Director so she was helping out with the notices of transfers. She stated, "We notify the family first and then let the resident know. Generally we try to give 48 hours notice but we are not always able. We assure the resident about the move. We try to show them the new room they will be going to. If not on the Cottage (secured unit) I walk with the resident the first time." When asked what notice was given to the resident who was receiving the new room mate, she replied, "We briefly say a new man or new woman is coming into your room today."</p> <p>During an interview on 1/15/13 at 10:43 A.M., the Executive Director indicated, Resident #7 had a room mate change on 11/13/12. She indicated the facility could not provide documentation he had been notified prior to the resident moving into his room.</p> <p>2) Resident #120's record was reviewed on 1/14/2013 at 12:38 P.M. Resident #120 was originally admitted to this facility on 8/3/2013 and</p>						

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	<p>readmitted on 10/26/2013. Resident #120 had current diagnoses which included: diabetes, hypertension, and congestive heart failure. A 30 day scheduled minimum data assessment tool (MDS), dated 12/10/12, indicated Resident #120 was cognitively intact.</p> <p>During an interview on 1/9/2013 at 10:12 A.M., Resident #120 indicated he had received a room mate change with in the last nine months. He denied receiving notice from facility staff prior to the room mate moving into his room. He stated, "No, no notice given."</p> <p>During an interview on 1/14/2013 at 2:11 P.M., The Memory Care Facilitator indicated the facility was currently without a Social Service Director so she was helping out with the notices of transfers. She stated, "We notify the family first and then let the resident know. Generally we try to give 48 hours notice but we are not always able. We assure the resident about the move. We try to show them the new room they will be going to. If not on the Cottage (secured unit) I walk with the resident the first time." When asked what notice was given to the resident who was receiving the new room mate, she replied, "We briefly say a new man or</p>						

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	<p>new woman is coming into your room today."</p> <p>During an interview on 1/15/13 at 10:43 A.M., the Executive Director (ED) indicated, Resident #120 had a room mate change on 11/21/12. She indicated the facility could not provide documentation he had been notified prior to the resident moving into his room.</p> <p>A current facility policy titled "ASC (American Senior Community) Intra-Facility Transfers" provided by the ED on 11/15/13 at 9:45 A.M. was reviewed. This policy indicated, ". . .Residents will be moved within the facility only when given appropriate notice . . .The receiving room mate and/or legal representative will be notified of the new room mate prior to the move. This notification will be documented in the medical record. Social services will follow up with both the resident who moved as well as the receiving roommate with 72 hours of the move. documentation will be placed as to the residents' adjustment to the move/new room mate."</p> <p>3.1-3(v)(2)</p>						

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to provide services in accordance with each residents' written plan of care for 1 of 22 residents interviewed for bathing/showers being provided (Resident # 97) and 1 of residents reviewed for receiving diets as ordered by the physician (Resident #33).</p> <p>Findings:</p> <p>1) Resident #97's record was reviewed on 1/11/2013 at 12:00 P.M. Resident #97 was admitted to this facility on 5/14/2012. Resident #97 had current diagnoses which included: chronic airway obstruction, hypertension, history of a fall, hemiplegia with hemiparalysis, osteoporosis, and depressive disorder. A quarterly minimum data set assessment tool (MDS), dated 12/29/12, indicated Resident #97 was alert and oriented, no behaviors of rejecting assistance with daily care or any care that was necessary to achieve the residents goals for health</p>		F0282	<p>F282 Services By Qualified Persons/Per Care Plan It is the practice of this facility to provide or arrange services in accordance with each resident's written plan of care by qualified persons.</p> <p>1. Resident #97 no longer resides in facility. Resident #33 was interviewed and re-educated and acknowledges understanding of risks associated with non-compliance of MD orders. MD and family were contacted. Order for thickened liquids was discontinued. Resident #33 plan of care was updated.</p> <p>2. Residents who reside at the facility have the potential to be affected by the alleged deficient practice. Licensed Nurses/Aides were re-educated related to protocol when resident's refuse showers by SDC by February 14, 2013. Residents who have altered fluids and non-compliance have the potential to be affected by this alleged deficient practice. Interdisciplinary team has reviewed those residents on altered fluids to ensure appropriate documentation for residents who are noncompliant.</p> <p>3. Licensed Nurses/Aides</p>		02/14/2013	

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	<p>and well being, and required total assistance of one staff for bathing.</p> <p>During an interview on 1/8/2013 at 10:55 A.M., Resident #97 stated, "I haven't had a shower since last Thursday. I asked my aide Monday (aide named). She works 2 to 10 and she said, 'there was only 2 of them on the floor.' Resident #97 was observed to be tearful at this time. Resident #97 stated, "I am leaving tomorrow to a different place (facility named). I am lucky if I get my butt wiped and washed half the time I feel dirty and grimy. My hair hasn't been washed since then. You know how you would feel. . .My daughter was here last night and she told me, 'Mom, you smell.' I told her what am I supposed to do about it." I have talked to (Executive Director (ED) named and another staff named). Monday and Thursday are my shower days." Resident #97 was observed at this time to have greasy hair.</p> <p>During an interview on 1/8/2012 at 11:00 A.M., The Director of Nursing Services (DNS) was asked to provide shower documentation for Resident #97. At 11:12 A.M. The DNS provided documentation which indicated Resident #97 had received bed baths or partials daily since</p>			<p>were re-educated related to protocol when resident's refuse showers by SDC by February 14, 2013. Residents are offered showers per their preference. Aides will fill out a shower sheet and document any refusal on the shower sheets. This is then turned into the licensed nurse who then gives them to the DNS/designee for monitoring. If resident has continued refusal care plan meeting will be held with family and residents to help resolve any identified issues. Staff has been re-educated on the altered fluid policy by the SDC by February 14, 2013. Nurse Managers/ Charge nurses will round every shift to ensure compliance with MD orders for thickened liquids. 4. Executive Director/designee will attend resident council meeting monthly x 3 to identify any issues related to activities of daily living. Data collected will be reviewed by the CQI committee monthly and action plans developed as needed. An Altered Fluid CQI tool will be completed weekly x4 and monthly x 6. If threshold is not achieved, an action plan will be developed.</p>			

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	<p>12/21/2012. The last shower documented was on 12/21/2012. At this time the DNS indicated Resident #97 had a history of refusing care. Documentation of Resident #97 refusing showers was requested at this time.</p> <p>A current care plan problem which originated on 5/15/12, indicated, Resident #97 had a self care deficit related to weakness and having left hemiparesis. A goal listed for her was that she would wash her hands and face daily. Approaches to meet this goal included: encourage resident to make choices in care such as clothing, shower time preference, etc, and to provide showers two times per week with a partial bath in between.</p> <p>A current care plan problem which originated 12/7/2012, indicated, Resident#97 had a behavior of refusing assistance from staff because she only wanted particular staff to assist her. A goal listed included Resident #97 would accept care from the assigned staff. Approaches to meet this goal included: take time with her, allow her to converse and vent feelings, have two staff assist, and re-approach at a later time if she</p>						

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	<p>refuses.</p> <p>A current care plan problem which originated 9/17/2012, indicated, Resident #97 was resistant care. At times she would refuse medications, showers, change of clothes. She was non-compliant with certain caregivers and would not allow care by them. A goal for Resident #97 included she would comply with recommended care through next review. Approaches to meet this goal included: resident will understand the potential negative consequences of refusing care, approach her in a polite manner and offer her a choice, for example, would you like to take your medicine now or in a few minutes? Ask her if she would prefer another staff member to help her. If she continued to refuse she would be educated on the negative consequences of refusing care and be re-approached at a later time.</p> <p>A current care plan problem which originated on 12/5/2012, indicated, Resident #97 made false accusations against staff. She often accused staff of not assisting her when she refused the staff who offered to assist her. A goal for her was she would understand if she refused the staff who were available, she might have</p>						

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	<p>to wait on assistance. An approach listed to meet this goal included staff would document refusal of care and care being offered.</p> <p>During an interview on 1/14/2013 at 12:31 P.M., the ED and the DNS were asked to provide a copy Resident #97's care plan, progress notes, and documentation related to Resident #97's refusals of showers along with any interventions that were being implemented as indicated by the current plan of care since 12/21/2012.</p> <p>The ED provided a copy of a grievance filed by Resident #97's daughter dated 12/27/12. This grievance indicated Resident #97 had not received a shower that week. As a result of the grievance being filed Resident #97 was given a shower on 12/27/2012.</p> <p>As of 1/15/2013 the facility was unable to provide documentation which indicated Resident #97 had received a shower since 12/27/2012 or documentation she had refused a shower since 12/21/2012. According to Resident #97 and the facility's documentation, eight days had passed since Resident #97 had received a shower.</p>						

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	<p>2) Resident #33's record was reviewed on 1/11/2013 at 9:32 A.M. Resident #33 was originally admitted to the facility on 2/4/2010 and readmitted on 2/1/2012. Resident #33 had current diagnoses which included: esophageal stricture, history of pneumonia, hemiplegia and hemiparesis, dysphagia, and aphasia. An annual minimum data set assessment tool (MDS), dated 12/25/2012, indicated Resident #33 was alert and oriented and required extensive assist of one person for locomotion on and off the unit.</p> <p>During an interview on 1/8/2012 at 9:49 A.M., Resident #33 stated, "I am not supposed to have water but I have it. The help bring it to me. I am supposed to have thickened nasty water. I throw it away." Observations made at this time revealed a pitcher of water with a lid and a straw and a cup without a lid with a straw containing unthickened water. Resident #33 laughed and indicated they were both unthickened water.</p> <p>The following observations were made: On 1/10/2013 at 12:59 P.M. A pitcher of unthickened water with a straw and a cup of unthickened water with a</p>						

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	<p>straw was sitting on the bedside table in Resident #33's room.</p> <p>On 1/13/2013 at 10:15 A.M., Resident #33 was observed drinking out of the cup with straw. The cup did not have a lid and it contained non thickened regular water. The pitcher of water sitting on the bedside table had a lid and a straw. Resident #33 indicated it was regular water (non thickened). He further indicated he ate in the main dining room because he had swallowing problems and could choke.</p> <p>During an interview on 1/13/2012 at 12:30 P.M., The Executive Director (ED) and the Director of Nursing Services) were asked to provide Resident #33's current physician's orders, current care plan, the last three months of progress notes including dietary and social service notes, and his most recent therapy notes.</p> <p>A current physician's order, dated January 1, 2013, indicated, Resident #33 was to have nectar thick liquids and not to use straws.</p> <p>A current care plan concern which originated on 12/13/2011, indicated Resident #33 required a mechanically</p>						

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	<p>altered diet related to dysphagia. He had a contributing diagnosis of esophageal stricture. He was non-compliant with the thickened liquids. His family brought in soft drinks for him. He and his family had been educated. A goal listed for him indicated, Resident #33 would tolerate the current diet consistency without signs or symptoms of difficulty chewing or swallowing. Interventions to meet this goal included: he would not have straws when drinking fluids, he would have fortified foods, his known food preferences would be honored, the medical doctor's (MD) ordered diet would be provided, and signs and symptoms of difficulty chewing or swallowing with current diet consistency would be observed.</p> <p>A current care plan concern which originated on 12/7/2011 indicated Resident #33 was having episodes of vomiting after meals and was at risk for choking due to a diagnoses of dysphagia and esophageal stenosis. Goals for him included, he would tolerate and accept the current diet order without signs/symptoms of difficulty chewing/swallowing. Approaches to meet this goal included, refer to dietary and speech therapy as needed and provide diet per MD order.</p>						

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	<p>A dietary note dated 1/2/2013 at 2:48 P.M. indicated, "Annual assessment note. Resident is receiving a mechanical soft diet with nectar thick liquids due to dx (diagnoses) of dysphagia. Resident tolerating current diet and fluid consistency without difficulty, intake recorded at 50/100% of meals served. . .Resident dx (diagnoses) includes Dysphagia, Depression, HTN (hypertension), Aphasia, and history of Aspiration Pneumonia. Will continue to follow as needed.</p> <p>3.1-35(g)(2)</p>						

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure residents who were unable to take a shower without the help of staff received the assistance needed for showers for 1 of 8 residents reviewed for activities of daily living (ADLs) being provided (Resident #97),</p> <p>Findings:</p> <p>1) Resident #97's record was reviewed on 1/11/2013 at 12:00 P.M. Resident #97 was admitted to this facility on 5/14/2012. Resident #97 had current diagnoses which included: chronic airway obstruction, hypertension, history of a fall, hemiplegia with hemiparalysis, osteoporosis, and depressive disorder. A quarterly minimum data set assessment tool (MDS), dated 12/29/12, indicated Resident #97 was alert and oriented, no behaviors of rejecting assistance with daily care or any care that was necessary to achieve the residents goals for health and well being, and required total</p>		F0312	<p>F 312 ADL Care Provided For Dependent Residents It is the practice of this facility to maintain good nutrition, grooming, and personal and oral hygiene to residents who are unable to carry out activities of daily living. 1. Resident #97 no longer resides at the facility. 2. Residents who reside at the facility have the potential to be affected by the alleged deficient practice. Licensed Nurses/Aides were re-educated related to protocol when resident's refuse showers by SDC by February 14, 2013. 3. Residents are offered showers per their preference. Aides will fill out a shower sheet and document any refusal on the shower sheets. This is then turned into the licensed nurse who then gives them to the DNS/designee for monitoring. If resident has continued refusal, a care plan meeting will be held with family and residents to help resolve any identified issues. 4. Executive Director/designee will attend resident council meeting monthly x 3 to identify any issues related to activities of daily living. Data collected will be</p>		02/14/2013	

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	<p>assistance of one staff for bathing.</p> <p>During an interview on 1/8/2013 at 10:55 A.M., Resident #97 stated, "I haven't had a shower since last Thursday. I asked my aide Monday (aide named). She works 2 to 10 and she said, 'there was only 2 of them on the floor.' Resident #97 was observed to be tearful at this time. Resident #97 stated, "I am leaving tomorrow to a different place (facility named). I am lucky if I get my butt wiped and washed half the time I feel dirty and grimy. My hair hasn't been washed since then. You know how you would feel. . .My daughter was here last night and she told me, 'Mom, you smell.' I told her what am I supposed to do about it." I have talked to (Executive Director (ED) named and another staff named). Monday and Thursday are my shower days." Resident #97 was observed at this time to have greasy hair.</p> <p>During an interview on 1/8/2012 at 11:00 A.M., The Director of Nursing Services (DNS) was asked to provide shower documentation for Resident #97. At 11:12 A.M. The DNS provided documentation which indicated Resident #97 had received bed baths or partials daily since 12/21/2012. The last shower</p>				<p>reviewed by the CQI committee monthly and action plans developed as needed.</p>		

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	<p>documented was on 12/21/2012. At this time the DNS indicated Resident #97 had a history of refusing care. Documentation of Resident #97 refusing showers was requested at this time.</p> <p>A current care plan problem which originated on 5/15/12, indicated, Resident #97 had a self care deficit related to weakness and having left hemiparesis. A goal listed for her was that she would wash her hands and face daily. Approaches to meet this goal included: encourage resident to make choices in care such as clothing, shower time preference, etc, and to provide showers two times per week with a partial bath in between.</p> <p>A current care plan problem which originated 12/7/2012, indicated, Resident#97 had a behavior of refusing assistance from staff because she only wanted particular staff to assist her. A goal listed included Resident #97 would accept care from the assigned staff. Approaches to meet this goal included: take time with her, allow her to converse and vent feelings, have two staff assist, and re-approach at a later time if she refuses.</p>						

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	<p>A current care plan problem which originated 9/17/2012, indicated, Resident #97 was resistant care. At times she would refuse medications, showers, change of clothes. She was non-compliant with certain caregivers and would not allow care by them. A goal for Resident #97 included she would comply with recommended care through next review. Approaches to meet this goal included: resident will understand the potential negative consequences of refusing care, approach her in a polite manner and offer her a choice, for example, would you like to take your medicine now or in a few minutes? Ask her if she would prefer another staff member to help her. If she continued to refuse she would be educated on the negative consequences of refusing care and be re-approached at a later time.</p> <p>A current care plan problem which originated on 12/5/2012, indicated, Resident #97 made false accusations against staff. She often accused staff of not assisting her when she refused the staff who offered to assist her. A goal for her was she would understand if she refused the staff who were available, she might have to wait on assistance. An approach</p>						

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	<p>listed to meet this goal included staff would document refusal of care and care being offered.</p> <p>During an interview on 1/14/2013 at 12:31 P.M., the ED and the DNS were asked to provide a copy Resident #97's care plan, progress notes, and documentation related to Resident #97's refusals of showers along with any interventions that were being implemented as indicated by the current plan of care since 12/21/2012.</p> <p>The ED provided a copy of a grievance filed by Resident #97's daughter dated 12/27/12. This grievance indicated Resident #97 had not received a shower that week. As a result of the grievance being filed Resident #97 was given a shower on 12/27/2012.</p> <p>As of 1/15/2013 the facility was unable to provide documentation which indicated Resident #97 had received a shower since 12/27/2012 or documentation she had refused a shower since 12/21/2012. According to Resident #97 and the facility's documentation, eight days had passed since Resident #97 had received a shower.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013  
FORM APPROVED  
OMB NO. 0938-0391

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	3.1-38(a)(2) 3.1-38(a)(3)(B) 3.1-38(b)(2)						

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to implement interventions to reduce the risk of residents choking for 1 of 1 residents reviewed with modified diets to prevent choking accidents (Resident #33).</p> <p>Findings:</p> <p>Resident #33's record was reviewed on 1/11/2013 at 9:32 A.M. Resident #33 was originally admitted to the facility on 2/4/2010 and readmitted on 2/1/2012. Resident #33 had current diagnoses which included: esophageal stricture, history of pneumonia, hemiplegia and hemiparesis, dysphagia, and aphasia. An annual minimum data set assessment tool (MDS), dated 12/25/2012, indicated Resident #33 was alert and oriented and required extensive assist of one person for locomotion on and off the unit.</p> <p>During an interview on 1/8/2012 at 9:49 A.M., Resident #33 stated, "I am</p>		F0323	<p>F323 Free Of Accidents Hazards/Supervision/Devices It is the practice of this facility that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>1. Resident #33 was interviewed and re-educated and acknowledges understanding of risks associated with non-compliance of MD orders. MD and family were contacted. Order for thickened liquids was discontinued. Resident #33 plan of care was updated.</p> <p>2. Residents who receive altered fluids and non-complaint have the potential to be affected by the alleged deficient practice. Interdisciplinary team has reviewed those residents on altered fluids to ensure appropriate documentation for residents who are noncompliant.</p> <p>3. Staff has been re-educated on the altered fluid policy by the SDC by February 14, 2013. Nurse Managers/Charge nurses will round each shift to ensure compliance with MD orders for thickened liquids.</p>		02/14/2013	

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	<p>not supposed to have water but I have it. The help bring it to me. I am supposed to have thickened nasty water. I throw it away." Observations made at this time revealed a pitcher of water with a lid and a straw and a cup without a lid with a straw containing unthickened water. Resident #33 laughed and indicated they were both unthickened water.</p> <p>The following observations were made: On 1/10/2013 at 12:59 P.M. A pitcher of unthickened water with a straw and a cup of unthickened water with a straw was sitting on the bedside table in Resident #33's room.</p> <p>On 1/13/2013 at 10:15 A.M., Resident #33 was observed drinking out of the cup with straw. The cup did not have a lid and it contained non thickened regular water. The pitcher of water sitting on the bedside table had a lid and a straw. Resident #33 indicated it was regular water (non thickened. He further indicated he ate in the main dining room because he had swallowing problems and could choke.</p> <p>During an interview on 1/13/2012 at 12:30 P.M., The Executive Director (ED) and the Director of Nursing</p>				<p>4.An Altered Fluid CQI tool will be completed weekly x4 and monthly x 6. If threshold is not achieved, an action plan will be developed.</p>		

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	<p>Services) were asked to provide Resident #33's current physician's orders, current care plan, the last three months of progress notes including dietary and social service notes, and his most recent therapy notes.</p> <p>A current physician's order, dated January 1, 2013, indicated, Resident #33 was to have nectar thick liquids and not to use straws.</p> <p>A current care plan concern which originated on 12/13/2011, indicated Resident #33 required a mechanically altered diet related to dysphagia. He had a contributing diagnosis of esophageal stricture. He was non-compliant with the thickened liquids. His family brought in soft drinks for him. He and his family had been educated. A goal listed for him indicated, Resident #33 would tolerate the current diet consistency without signs or symptoms of difficulty chewing or swallowing. Interventions to meet this goal included: he would not have straws when drinking fluids, he would have fortified foods, his known food preferences would be honored, the medical doctor's (MD) ordered diet would be provided, and signs and symptoms of difficulty chewing or swallowing with current</p>						

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	<p>diet consistency would be observed.</p> <p>A current care plan concern which originated on 12/7/2011 indicated Resident #33 was having episodes of vomiting after meals and was at risk for choking due to a diagnoses of dysphagia and esophageal stenosis. Goals for him included, he would tolerate and accept the current diet order without sighs/symptoms of difficulty chewing/swallowing. Approaches to meet this goal included, refer to dietary and speech therapy as needed and provide diet per MD order.</p> <p>A dietary note dated 1/2/2013 at 2:48 P.M. indicated, "Annual assessment note. Resident is receiving a mechanical soft diet with nectar thick liquids due to dx (diagnoses) of dysphagia. Resident tolerating current diet and fluid consistency without difficulty, intake recorded at 50/100% of meals served. . .Resident dx (diagnoses) includes Dysphagia, Depression, HTN (hypertension), Aphasia, and history of Aspiration Pneumonia. Will continue to follow as needed.</p> <p>3.1-45(a)(2)</p>						

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F0334 SS=D	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>						

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview, the facility failed to annually inform residents about the benefits and risks of the pneumococcal pneumonia vaccination who was eligible to receive the vaccination. This deficient practice affected 1 of 5 residents reviewed for receipt of information regarding the immunizations [Residents #22].</p> <p>Findings include:</p> <p>On 1/14/13 at 9:32 A.M., Resident #22's record was reviewed.</p> <p>Diagnoses included, but were not</p>	F0334	<p>F 334 Influenza and Pneumococcal Immunizations</p> <p>It is the practice of this facility to ensure that annually the facility informs residents about the benefits and risks of the pneumococcal pneumonia vaccination who is eligible to receive the vaccination.</p> <p>1. Resident # 22 responsible party received the required education for the pneumococcal pneumonia vaccine. Family/resident declined the immunization.</p> <p>2. Residents who are 65 or older have the potential to be affected by the alleged deficient practice. A facility audit was completed to</p>		02/14/2013		

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	<p>limited to, hemiplegia/hemiparesis, aphasia, syncope and collapse, diabetes mellitus type II, and dementia.</p> <p>There was no documentation in the resident's record regarding receipt of the pneumococcal pneumonia vaccine and there was not documentation regarding the resident's receipt of information regarding the immunization.</p> <p>On 1/15/13 at 2:00 P.M., the Director of Nursing provided a "Pneumococcal Vaccination Consent" dated 1/15/13 that indicated the Resident #22's daughter declined vaccination as of 1/15/13 and the resident had no previous pneumococcal vaccination.</p> <p>On 1/15/13 at 2:15 P.M., in an interview, the Director of Nursing indicated she could not provide annual documentation for 2012 in regard to the resident receiving the required education for the pneumococcal pneumonia vaccine.</p> <p>The "Pneumococcal Vaccine" policy and procedure, included, but was not limited to, "The resident will be offered pneumococcal vaccine annually, if appropriate... Pneumococcal vaccine is</p>		<p>ensure those eligible for the pneumococcal pneumonia were completed.</p> <p>3. Upon admission residents will be offered if eligible for the pneumococcal pneumonia vaccine. Residents who are eligible and have declined will be re-educated regarding risk and benefits by Licensed Nurses.</p> <p>4. The resident immunizations CQI will be completed to monthly for 3 months and quarterly thereafter. Data collected will be reviewed by the CQI committee for action plan if indicated. If threshold not met an action plan will be completed.</p>				

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	<p>recommended for residents over the age of 65. No further doses are required for residents vaccinated after the age of 65, unless specifically ordered by physician... On admission, residents will be screened for pneumococcal vaccine... If resident meets the criteria for pneumococcal vaccine, the resident will be offered the opportunity to receive the pneumococcal vaccine... Each resident will be instructed on the risks of the vaccine, including possible side effects..."</p> <p>3.1-13(a)</p>						

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F0371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure proper sanitation to prevent contamination of pans used to hold food served to residents and by failing to dispose of expired milk intended for resident consumption. This deficient practice had the potential to affect 86 of 86 residents who ate food served from the facility's kitchen.</p> <p>Findings:</p> <p>On 1/7/2013 beginning at 1:00 P.M., observations of the kitchen were made. The Dietary Manger was present for the tour.</p> <p>1) Four deep silver pans used to hold food and other dishes were soaking in the third sink. Dietary staff #1 indicated the first of the three sinks was for washing, the second was for rinsing, and the third sink was for sanitizing. The pans were soaking in the sanitizing sink. At this time she was asked to check the sanitation</p>		F0371	<p>F 371 Food Procure, Store/Prepare/Serve-Sanitary It is the practice of this facility to ensure proper sanitation to prevent contamination of pans and disposal of expired milk. 1. There was no identifier list for the alleged deficient practice. 2. Residents who consume food by mouth have the potential to be affected by the alleged deficient practice. 3. Registered Dietician re-educated dietary staff on sanitation requirements for sanitizing sink. Registered Dietician re-educated dietary staff on rotation of products and monitoring daily of expired milk by February 14, 2013. 4. Registered Dietician will do a monthly sanitization check to ensure compliance. CDM will monitor 3 x week for correct sanitation level in the sanitizing sink and audit for expired milk. The CQI committee will review data collected, an action plan will be developed if threshold is not achieved.</p>		02/14/2013	

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	<p>solution level. She was asked prior to checking the level what it should be. She indicated 200. She obtained the strips and checked the sanitation level. According to the strips and the instructions on the bottle of strips the sanitation level was only 100. Dietary staff #1 was asked to check it again to make sure. She checked it again and the result was the same. She stated, "It is not strong enough." She asked, "(Dietary staff #2 named) How many tabs did you put in the water?." He replied, "7." Dietary staff #2 came over to the sink and said, "You have too much water in the sink. It should only be filled to the fill line."</p> <p>2) The Dietary Manager opened the milk carton holding cooler. Nine cartons of fat free milk located in the top front crate of the cooler had expiration dates from 12/31/12 thru 1/3/2013. She indicated at this time staff were to check these dates daily and they should have been thrown out.</p> <p>3.3-21(i)(3)</p>						

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to implement</p>			F0441	F 441 Infection Control, Prevent Spread, Linens It is the		02/14/2013

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	<p>appropriate hand hygiene for 2 of 2 residents observed during a dining observations (Resident #7 and Resident #123). observations.</p> <p>Findings:</p> <p>On 1/8/13 beginning at 12:10 P.M., dining observations were made in the main dining room. The following observations were made:</p> <p>At 12:45 Resident #7 and Resident #123 were observed sitting at a table together. Certified Nursing Assistant #4 was observed serving hot tea and hot chocolate to the residents. She prepared Resident #7's hot tea. She proceeded to help him drink his tea. Without sanitizing her hands she assisted Resident #123 lift his cup to his mouth. At this time Resident #7's feet fell off the wheel chair foot pedals. CNA #4 repositioned Resident #7 and lifted his feet with her hands and put them back on the foot pedals. Without sanitizing her hands she picked up Resident #123's sandwich handed it to him. At this time Resident #7's feet again fell off of the foot pedals so CNA #4 without sanitizing her hands assisted Resident #7 by lifting each foot back onto the foot pedals. At this time she sanitized her hands with hand gel.</p>				<p>practice of this facility to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>1. Resident #7 and Resident #123 received fluids and food in a sanitary manner.</p> <p>2. Residents who reside at the facility have the potential to be affected by the alleged deficient practice. Nursing staff have been re-educated on hand sanitization during meals by SDC by February 14, 2013.</p> <p>3. Upon hire, employees are educated on hand washing and sanitizing of hands. Department Managers/charge nurses and or designee will monitor meals daily to ensure of proper hand sanitizing between residents.</p> <p>4. The Meal Service Observation CQI will be completed weekly for four weeks, monthly for at least six months, and quarterly thereafter. If threshold of 90% is not achieved, an action plan will be developed.</p>		

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	<p>Review of a current facility policy titled, "Dietary Personal Hygiene", provided by the Executive Director (ED) on 1/15/2012 at 9:45 A.M., indicated," . . . Proper hand washing is the most critical aspect of personal hygiene. Dietary employees must was their hands before they start work and after: . . . touching the hair, face, or body, clearing tables, touching clothing or aprons, touching anything else that may contaminate hands . . .after patient contact, after contact with patient surroundings . . ."</p> <p>3.1-18(j)</p>						

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F9999	<p>9999 [personnel] 3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD)... The tuberculin skin test must be read prior to the employee starting work... (1) For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step...</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to provide employees with tuberculin skin testing in the time required by Indiana State Department of Health. This deficient practice affected 5 of 14 employee files reviewed for tuberculin skin testing. [Licensed Practical Nurse #10, Certified Nursing Assistant #11,</p>		F9999	<p>9999 Personnel It is the practice of this facility to ensure that employees receive a first and second Step PPD and a physician exam upon hire.</p> <p>1.No residents were identified in this alleged deficient practice.</p> <p>2.LPN # 10, Certified Nursing Assistant #11 &amp; 12, Dietary Aide # 13, and Activity Assistant # 14 will receive a 1 st and 2 nd step PPD.</p> <p>3.Upon hire employees will receive their 1 st step PPD and physical exam. The 2 nd step PPD will be scheduled 1-3 weeks from hire. A facility audit was completed to ensure all employees have a current 1 st and 2 nd step PPD and physical. SDC will monitor new employees to ensure compliance.</p> <p>4.A new employee checklist will be utilized upon hire to ensure that PPD's and Physicals are current. Data collected will be referred to the CQI committee for review.</p>		02/14/2013	

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	<p>Certified Nursing Assistant #12, Activity, Dietary Aide #13, and Activity Assistant #14] In addition, the facility failed to ensure employees had a physical examination in the time required by Indiana State Department of Health. The physical examination was not completed prior to the employee's first day of resident contact. This deficient practice affected 2 of 8 employee files reviewed for physical examinations. [Certified Nursing Assistants #11 and #12].</p> <p>Findings include:</p> <p>On 1/15/13 at 1:00 P.M., facility employee records were reviewed.</p> <p>1. Licensed Practical Nurse [LPN] #10's employee file included, but was not limited to a hire date of 8/8/12 and a "Tuberculin [TB] Testing For Employees" dated 8/8/12 that indicated a first step TB skin test was given on 8/8/12. There was no documentation of a second step TB skin test within the State required time frame.</p> <p>2. Certified Nursing Assistant [CNA] #11's employee file included, but was not limited to a hire date of 10/8/12 and a "Tuberculin [TB] Testing For</p>						

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	<p>Employees" dated 10/2/12 that indicated a TB skin test was given on 10/2/12. There was no documentation of a second step TB skin test within the State required time frame.</p> <p>In addition, CNA #11's employee file included a "Physical Exam" dated 1/12/13. There was no documentation of a physical exam prior to 1/12/13 in CNA #11's employee file.</p> <p>3. CNA #12's employee file included, but was not limited to a hire date of 10/8/12. There was no documentation of a TB skin test prior to 11/11/12.</p> <p>In addition, CNA #12's employee file included a "Physical Exam" dated 1/12/13. There was no documentation of a physical exam prior to 1/12/12 in CNA #12's employee file.</p> <p>4. Dietary Aide #13's employee file included, but was not limited to a hire date of 10/18/12 and a "Tuberculin [TB] Testing For Employees" dated 9/13/12 that indicated a TB skin test was given on 10/13/12. There was no documentation of a second step TB skin test within the State required</p>						

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	<p>time frame.</p> <p>5. Activity Assistant #14's employee file included, but was not limited to, an annual "Tuberculin Testing For Employees" dated 9/20/11. There was no documentation of an annual TB skin test dated 9/2012.</p> <p>On 1/15/13 at 1:30 P.M., the Director of Nursing provided a policy, "Employee Health" dated 10/2011.</p> <p>The policy included, but was not limited to, "Each employee must have a post hire physical assessment. The assessment shall ensure that the employee: Is sufficiently free of symptoms of active disease, and physically able to safely perform the essential functions of the job, Has no health conditions that would cause hazard to them or another individual, including residents, Is free of active Tuberculosis disease..."</p> <p>On 1/15/13 at 2:00 P.M., in an interview, the Executive Director indicated she was aware there was a problem with the employee records as the facility has had a turnover in staff.</p> <p>3.1-14(t)(1)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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